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1.0 Description of Fetal Surveillance

Fetal surveillance testing may be necessary to ensure that the fetus is developing normally. The predominant goal of antepartum fetal testing is to lower perinatal morbidity and mortality rates. Fetal testing should not begin until interventions can be undertaken.

1.1 Ultrasound

Ultrasound is a method of imaging the fetus and the female pelvic organs during pregnancy. A hand-held device is passed over the abdominal surface, recording the echoes of high-frequency sound waves as they are transmitted through tissues with varying density. Ultrasound is used to determine abnormal conditions of pregnancy or other conditions affecting the fetus and future delivery. Doppler ultrasound studies are used to confirm or exclude fetal anemia and help determine timing of delivery.

1.2 Fetal Contraction Stress Testing

Fetal contraction stress testing is a method of assessing fetoplacental respiratory reserve by observing the response of the fetal heart rate to uterine contractions to determine if the fetus is adequately oxygenated.

1.3 Fetal Non-stress Testing

Fetal non-stress testing is a noninvasive method of assessing fetal well-being by observing the response of the fetal heart rate to fetal movement and uterine activity by external means. A uterine monitor is used and the measurements are observed and recorded.

1.4 Biophysical Profile

The biophysical profile (BPP) includes a non-stress test and the following four ultrasonography observations:

- a. Fetal breathing movements
- b. Fetal movement
- c. Fetal tone (one or more episodes of a fetal extremity with return to flexion, or opening or closing of a hand)
- d. Determination of the amniotic fluid volume

1.5 Fetal Echocardiography

Fetal echocardiography is a diagnostic fetal ultrasound test that evaluates the fetus's heart while the fetus is still in the uterus. This testing can diagnose most cardiac defects. Fetal echocardiography is performed using a two-dimensional (2-D) high-resolution ultrasound system. Doppler flow mapping may be used to identify the area affected with an altered blood flow. Techniques sometimes used to obtain detailed information about the fetal heart include 2-D echocardiography, Doppler echocardiography, and color Doppler echocardiography.

1.6 Amniocentesis

Amniocentesis is an ultrasound-guided procedure used to diagnose various prenatal genetic defects and other fetal conditions. Generally performed at or beyond 14 weeks gestation for genetic testing amniotic fluid is withdrawn from the mother through a needle inserted in the amniotic sac. An ultrasound is usually performed simultaneously to guide the insertion of the needle. The fluid is used to diagnose fetal genetic abnormalities, diagnose intrauterine infection, assess fetal lung maturity, and establish the severity of hemolytic disease in blood group isoimmunization.

1.7 Chorionic Villus Sampling

Chorionic villus sampling (CVS) is an ultrasound-guided procedure performed during pregnancy at 10 and 12 weeks to determine congenital chromosome disorders and to detect suspected genetic abnormalities in the fetus. It involves taking samples from the placenta in the early stages of pregnancy to check for the presence of genetic defects in the fetus.

1.8 Cordocentesis

Cordocentesis, also call percutaneous umbilical blood sampling (PUBS) is an ultrasound-guided procedure performed to genetic testing or to evaluate severity of fetal anemia. The fetal umbilical cord is visualized with ultrasound while a needle is passed from the surface of the mother's abdomen, through the uterus, into the umbilical cord. A small sample of fetal blood is withdrawn for testing.

1.9 Fetal Fibronectin

Fetal fibronectin (fFN) immunoassay is a qualitative test of cervicovaginal secretions for the detection of fFN protein, which anchors the amniotic membranes to the wall of the uterus. When the "anchor" breaks, the fFN leaks into the vagina, and provides a clue that the woman may be going into preterm labor (when the cervix softens or dilates, with or without labor pains, before 37 weeks' gestation). The test therefore predicts preterm delivery.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Gender and Age

Female recipients from ages 9 through 60 are eligible for the procedure when they meet the medical necessity criteria listed in **Section 3.0**.

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a

condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/medbillcaguide.htm>

EPSDT provider page: <http://www.ncdhhs.gov/dma/EPSTDprovider.htm>

3.0 When the Procedure Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers fetal surveillance when it is medically necessary and:

- a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Medically Necessary Ultrasound

Medicaid considers ultrasound to be medically necessary when it is used as a diagnostic tool for the following conditions.

- a. Abnormality in pregnancy such as, but not limited to:
 - Suspected ectopic pregnancy
 - Suspected hydatidiform mole
 - Threatened or missed abortion
 - Congenital malformations, fetal or maternal
 - Polyhydramnios/oligohydramnios
 - Placenta previa
 - Abrupto placenta
 - Vaginal bleeding
- b. A medical condition threatening the fetus and/or delivery such as, but not limited to:
 - Suspected abnormal presentation
 - Suspected multiple gestation
 - Significant difference between the size of the uterus and the time the fetus has been in the womb
 - Elevated maternal serum alpha-fetoprotein
 - Suspected genetic abnormality due to abnormal maternal serum screening (QUAD Screen) or maternal age greater than 35.
 - Suspected fetal death
 - Suspected anatomical abnormality of the uterus
 - Maternal risk factors such as family history of congenital abnormalities, chronic systemic disease (hypertension, diabetes, sickle cell disease), or substance abuse
 - Suspected fetal growth abnormality, either growth retardation or macrosomia
- c. Confirmation of the estimated date of conception when the clinical history and examination are not certain. In general, a single ultrasound performed prior to 20 weeks' gestation is sufficient for this purpose.

- d. Follow-up ultrasounds may be medically necessary if the study will be used to alter or confirm a treatment plan.
- e. Umbilical artery Doppler velocimetry is considered medically necessary in evaluating pregnancies complicated by intra-uterine growth restriction, oligohydramnios, and/or discordant twins.
- f. Middle cerebral artery Doppler velocimetry is considered medically necessary for evaluation of suspected fetal anemia in conditions such as isoimmunization and parvovirus B-19 infection.

3.3 Fetal Contraction Stress Testing

Fetal contraction stress testing is covered only for high-risk pregnancies including, but not limited, to the following:

- a. Anti-phospholipid syndrome
- b. Hyperthyroidism (poorly controlled)
- c. Hemoglobinopathies (hemoglobin SS, SC, or S-thalasemia)
- d. Cyanotic heart disease
- e. Pregestational diabetes
- f. Hypertensive disorders
- g. Pregnancy-induced hypertension
- h. Decreased fetal movement
- i. Oligohydramnios
- j. Polyhydramnios
- k. Intrauterine growth restriction
- l. Post-term pregnancy(greater than 41 weeks' gestation)
- m. Isoimmunization (moderate to severe)
- n. Previous fetal demise (unexplained or recurrent risk)
- o. Multiple gestation (with significant growth discrepancy)

3.4 Fetal Non-Stress Testing

Medicaid covers fetal non-stress testing for a high-risk pregnancy when:

- a. Pregnancy is at least at a gestation of 26 weeks, **and**
- b. There is a high risk that the fetus' health could be compromised because of one of the following conditions, including but not limited to:
 - 1. Maternal conditions associated with uteroplacental compromise:
 - Diabetes mellitus (pre-existing or pregnancy related)
 - Underlying maternal hypertension
 - Pregnancy-induced hypertension
 - Anti-phospholipid syndrome
 - Hyperthyroidism (poorly controlled)
 - Hemoglobinopathies (hemoglobin SS, SC, or S-thalasemia)
 - Cyanotic heart disease
 - Isoimmunization (moderate to severe)
 - Previous fetal demise (unexplained or recurrent risk)

2. Fetal conditions associated with uteroplacental compromise:
 - Fetal distress, identified by clinical history or examination
 - Poor fetal growth
 - Decreased fetal movement
 - Oligohydramnios
 - Polyhydramnios
 - Preterm premature rupture of membranes
 - Intrauterine growth restriction
 - Post-term pregnancy(greater than 41 weeks' gestation)
 - Multifetal gestation (with significant growth discrepancy).
 - Known fetal anomaly
3. Other suspected causes of fetal distress

3.5 Fetal Biophysical Profiles

Medicaid covers fetal BPPs for a high-risk pregnancy when:

- a. Pregnancy is at least at a gestation of 26 weeks, **and**
- b. There is a high risk that the fetus' health could be compromised because of one of the following conditions, including but not limited to:
 - Inconclusive Non-Stress testing (Non-Reactive) or
 - Indications listed for Non-Stress Test above

3.6 Fetal Echocardiography

Fetal echocardiography is covered as a diagnostic tool for a fetus at high risk for congenital heart disease.

3.6.1 Fetal Risk Factors

- a. Extracardiac abnormality
- b. Chromosomal abnormality
- c. Fetal cardiac arrhythmia
- d. Non-immune hydrops
- e. Question of cardiac anomaly on prior sonogram
- f. Intrauterine growth retardation
- g. Family history of congenital heart disease (parent or sibling)

3.6.2 Maternal Risk Factors

- a. Family history of congenital heart disease (parent or sibling, or prior child)
- b. Teratogenic exposure (e.g., alcohol, amphetamines, anticonvulsives, lithium)
- c. Maternal disorders (e.g., diabetes mellitus, collagen vascular disease, maternal infection , phenylketonuria)
- d. Inherited familial syndromes
- e. Suspected genetic abnormality due to abnormal maternal serum screening or maternal age greater than 35.

3.7 Amniocentesis

Medicaid covers amniocentesis for the following clinical indications:

- a. to diagnose or determine the severity of neural tube defect
- b. in pregnancy where the mother will be 35 years of age or older at the expected time of delivery
- c. when a previous pregnancy resulted in the birth of a child with chromosomal or genetic abnormality or major malformations
- d. when a chromosomal or genetic abnormality is known to exist in either parent
- e. when a history of chromosomal or genetic abnormality is present in a blood relative
- f. abnormal maternal serum screening
- g. where there is history of three or more spontaneous abortions in this relationship or in a previous mating of either partner
- h. other conditions associated with increased risk for fetal aneuploidy such as first trimester thickened nuchal translucency.
- i. when the fetus is at increased risk for a detectable metabolism error
- j. for fetal sex determination in pregnancies at risk for an X-linked hereditary disorder such as, but not limited to the following:
 - hemophilia
 - mental retardation
 - hydrocephalus
 - Duchenne's muscular dystrophy
- k. to diagnose and monitor Rh incompatibility
- l. to gauge fetal lung maturity when early delivery is anticipated
- m. to control polyhydramnios (reduction amniocentesis)

3.8 Chorionic Villus Sampling

Medicaid covers CVS for the following clinical indications:

- a. in pregnancy where the mother will be 35 years of age or older at the expected time of delivery.
- b. when a previous pregnancy resulted in the birth of a child with chromosomal or genetic abnormality or major malformations.
- c. when a chromosomal or genetic abnormality is known to exist in either parent.
- d. when a history of chromosomal or genetic abnormality is present in a blood relative.
- e. when there is history of three or more spontaneous abortions in this relationship or in a previous mating of either partner.
- f. other conditions associated with increased risk for fetal aneuploidy such as first trimester thickened nuchal translucency.
- g. when the fetus is at increased risk for metabolism error, detectable in vitro.
- h. for fetal sex determination in pregnancies at risk for an X-linked hereditary disorder such as, but not limited to the following:

- hemophilia
- mental retardation
- hydrocephalus
- Duchenne's muscular dystrophy

3.9 Cordocentesis

Medicaid covers cordocentesis for the following indications:

- a. suspected chromosome abnormality when rapid diagnosis will influence management
- b. suspected fetal hematologic abnormality when confirmation will influence management

3.10 Fetal Fibronectin Testing

Medicaid covers fFN testing when all of the following criteria are met:

- a. amniotic membranes are intact; and
- b. cervical dilation is minimal (less than 3 cm); and
- c. sampling is performed between 24 weeks, 0 days and 34 weeks, 6 days of gestation.

4.0 When the Procedure Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Fetal surveillance is not covered when:

- a. The recipient does not meet the eligibility requirements listed in **Section 2.0**.
- b. The procedure duplicates another provider's procedure.
- c. The procedure is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Medicaid does not cover fetal surveillance when the recipient does not meet the medical necessity criteria listed in **Section 3.0**.

4.2.1 Ultrasound

Ultrasound is not covered when:

- a. it is a screening test used in the absence of medical indications or predisposing factors; or
- b. it is used solely to determine the sex of the fetus.

4.2.2 Fetal Echocardiography

Fetal echocardiography is not covered when:

- a. it is used for routine screening for congenital heart disease in the absence of risk factors listed in **Section 3.5**; or
- b. the pregnancy is low risk and there are normal anatomic findings on ultrasound examination; or
- c. premature contractions are occasional and without sustained tachycardia or signs of dysfunction or distress; or
- d. a non-cardiovascular system abnormality is present, but evaluation of the cardiovascular system will not alter either obstetrical decision making or fetal outcome.

4.2.3 Amniocentesis

Amniocentesis is not covered when it is performed for the following reasons:

- a. sex determination, in the absence of a documented risk of an X-linked disorder, or
- b. routine screening, in the absence of risk factors noted in **Section 3.6**.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

Prior approval is not required.

5.2 Limitations

5.2.1 Ultrasound

Medicaid covers up to three ultrasounds in 40 weeks before a high-risk diagnosis must be on the claim. Beginning with the fourth ultrasound, must be satisfied by a diagnosis that supports a high-risk pregnancy.

5.2.2 Fetal Non Stress Testing

Medicaid covers up to three fetal non-stress tests in a 280-day period or 40 weeks before a high-risk diagnosis must be on the claim. All non-stress tests must be medically necessary. Claim diagnoses will be reviewed for high-risk pregnancy.

5.2.3 Fetal Biophysical Profiles

Medicaid allows fetal BPPs to be performed on each fetus. The diagnosis must support the number of units billed. Example: Two units can be billed when a BPP is performed on twins.

5.2.4 Fetal Echocardiography

Fetal echocardiography is allowed twice in a 280-day period. Claims submitted for testing that exceeds this limit will be reviewed for medical necessity.

Note: The intent of the above limitations is not to prevent or interfere with medically necessary repetition but to prevent medically unnecessary duplication. All fetal surveillance procedures must be medically necessary.

6.0 Providers Eligible to Bill for Fetal Surveillance

Providers who meet Medicaid's qualifications for participation and are currently enrolled in the N.C. Medicaid program are eligible to bill for fetal surveillance when the procedure is within the scope of their practice.

7.0 Additional Requirements

There are no additional requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: December 1, 1982

Revision Information:

Date	Section Updated	Change
4/1/07	Sections 1.1 and 3.2, Attachment A	Coverage expanded to include chorionic villus sampling (59015)
4/1/07	Sections 1.7 and 3.8, Attachment A	Coverage expanded to include doppler velocimetry (76820, 76821)

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Physicians, emergency room physicians, medical diagnostic clinics, nurse practitioners, nurse midwives, and health departments enrolled in the N.C. Medicaid program bill services on the CMS-1500 claim form.

B. Diagnosis Codes

Providers must bill the appropriate ICD-9-CM diagnosis code that supports medical necessity.

C. Procedure Code(s)

Ultrasound in Maternity Care	
Code	Description
76801	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation
76802	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; each additional gestation
76805	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation
76810	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; each additional gestation
76811	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation
76812	Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; each additional gestation
76815	Ultrasound, pregnant uterus, real time with image documentation, limited (e.g., fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses
76816	Ultrasound, pregnant uterus, real time with image documentation, follow-up (e.g., re-evaluation of fetal size by measuring standard growth parameters and amniotic fluid volume, re-evaluation of organ system(s) suspected or confirmed to be abnormal on a previous scan), transabdominal approach, per fetus
76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal
76820	Doppler velocimetry, umbilical artery
76821	Doppler velocimetry, middle cerebral artery (MCA)

Fetal Oxytocin Stress Testing	
59020	Fetal contraction stress test

Fetal Non-Stress Testing	
59025	Fetal non-stress test

Biophysical Profile	
76818	Fetal biophysical profile; with non-stress testing
76819	Fetal biophysical profile; without non-stress testing

Fetal Echocardiography	
76825	Echocardiography, fetal, cardiovascular system, real-time with image documentation (2D), with or without M-mode recording
76826	Echocardiography, fetal, cardiovascular system, real-time with image documentation (2D), with or without M-mode recording; follow-up or repeat study
76827	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; complete
76828	Doppler echocardiography, fetal, pulsed wave and/or continuous wave with spectral display; follow-up or repeat study
93325	Doppler echocardiography color flow velocity mapping

Amniocentesis	
59000	Amniocentesis; diagnostic
59001	Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)
76946	Ultrasonic guidance for amniocentesis, imaging supervision and interpretation
82143	Amniotic fluid scan (spectrophotometric)
82963	Glucosidase, beta
83661	Fetal lung maturity assessment, lecithin sphingomyelin (L/S) ratio
83662	Foam stability test
83663	Florescence polarization
83664	Lamellar body density
84081	Phosphatidylglycerol
88235	Amniotic or chorionic villus cells
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding
88269	Chromosome analysis, in situ for amniotic fluid cells, count cells from 6-12 colonies, 1 karyotype, with banding

Chorionic Villus Sampling	
59015	Chorionic villus sampling , any method
76945	Ultrasonic guidance for chorionic villus sampling, imaging supervision and interpretation
88235	Amniotic or chorionic villus cells
88267	Chromosome analysis, amniotic fluid or chorionic villus, count 15 cells, 1 karyotype, with banding

Cordocentesis	
59012	Cordocentesis (intrauterine), any method

Fetal Fibronectin Testing	
82731	Fetal fibronectin assay

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Inpatient, Outpatient, Physician's Office

F. Reimbursement

Providers must bill their usual and customary charges.

G. Billing Guidelines for Fetal Surveillance

1. Medicaid does not allow separate reimbursement for components included in more comprehensive procedures. For example:
 - Fetal heart monitoring is included with non-stress testing and is not separately reimbursable.
 - Medicaid does not allow separate reimbursement for fetal monitoring performed during labor.
2. A medically necessary repeat or follow-up fetal ultrasound on the same date of service must be filed as an adjustment with medical records.
3. A fetal non-stress test (CPT code 59025) cannot be billed with fetal biophysical profile (CPT code 76818).
4. Neither fetal oxytocin stress testing (CPT code 59020) nor non-stress testing (CPT code 59025) can be billed on the same date of service as labor room delivery (RC720).
5. The number of fetal biophysical profiles billed must match the diagnosis billed. Example: if the diagnosis is 6510 (twin pregnancy), the number of fetal biophysical profiles billed cannot exceed two.
6. Medicaid covers other procedures performed on the same date of service as amniocentesis if performed by the same provider and billed according to modifier rules.
7. Medicaid covers other related procedures performed during the amniocentesis follow-up period and unrelated procedures performed during the follow-up period if performed by the provider who performed the amniocentesis.

H. Billing Guidelines for Ultrasounds for Multiple Fetuses

When billing for the ultrasound of multiple fetuses, the following guidelines should be observed.

1. The primary transabdominal code must be billed as one detail with one unit of service. (These codes are 76801, 76805, and 76811.)
2. The add-on code must be billed on one detail line with the units of service equaling the number of additional fetuses (76802, 76810, and 76812).
3. Each add-on code must be billed with the correct primary code.

4. The add-on codes for “each additional fetus” must be billed with the appropriate multiple gestation diagnosis code from the 651 range of ICD-9-CM codes. (Do not use the fifth-digit subclassification digit 0.) The units billed for the add-on ultrasound procedure code is based on the number of “each additional” living fetus(es).
5. One combination of primary and add-on ultrasound codes is allowed per day. Claims denied for additional ultrasounds may be resubmitted as an adjustment with documentation to support the medical necessity of a repeat ultrasound on the same date of service.
6. 76815 is defined to include “one or more fetuses” and can only be reimbursed for one unit of service.
7. When billing 76816 for multiple fetuses, bill 76816 on one detail without a modifier and with one unit for the first fetus. Additional fetuses must be billed on the next detail line using 76816 with modifier 59; the units should equal the number of additional fetuses. This code must also be billed with the appropriate diagnosis code from the 651 series of diagnosis codes as outlined above.
8. In addition to the transabdominal ultrasounds, one unit of 76817 is covered on the same date of service if medically necessary. No modifier is needed. Medical necessity must be documented in the recipient’s medical record.
9. Fetal biophysical profiles (76818 and 76819) are covered for additional fetuses. The profile for the first fetus must be billed on one detail, no modifier, and one unit of service. Profiles for additional fetuses must be billed on the next detail, using modifier 59, with the number of units equaling the number of additional fetuses. The appropriate diagnosis code from the 651 series should be billed as outlined above.
10. Claims for fetal biophysical profiles submitted with more than one unit and without the appropriate diagnosis code will be denied. Providers should correct the claim and resubmit as a new claim.
11. Claims for multigestational transabdominal ultrasounds submitted without the appropriate diagnosis will be denied. Providers should correct the claim and resubmit as a new claim.
12. Medical records are required for multiple gestation diagnosis codes from the 651 range that note “fetal loss” or “other” and/or “unspecified multiple gestation.”
13. In cases of fetal demise, the ultrasound procedure that confirms the loss of one, or more, fetuses may be billed with units to include the total number of additional fetuses, dead and living. Subsequent billings should be billed with the units based on the number of “each additional” living fetus.
14. A fetal biophysical profile must not be billed for a fetus that has died.
15. CPT code 76830 must not be billed for a transvaginal ultrasound performed for any pregnancy related condition.
16. Because pregnancies with multiple fetuses are high-risk pregnancies, there is no limit to the number of ultrasounds performed during the pregnancy when billed according to these instructions. However, excessive billing of ultrasounds during a pregnancy is subject to post-payment review for medical necessity, which must be documented in the medical record.